## Legal Entity Provider Readiness Testing: Claiming

Provider Claiming Readiness Testing will consist of five required phases.

1) The first phase is verification with the provider that the IBHIS setup is complete and the types of services that will be tested.
2) The second phase is verification that client's financial eligibility has been submitted correctly through Client Web Services.
3) The third phase is a verification of the claiming scenarios.
4) The fourth phase is verification of Replacement claiming scenarios.
5) The fifth phase is verification of Void claiming scenarios.

Note:

1) For testing purposes, all 837 Rendering Provider records must have been active in the IS as of January 2013.

### *IBHIS Setup and Testing Verification:*

Provider and testing analyst will confirm the following information:

1) Submitter ID/DUNS Number
2) 835 Defaults – information that will appear on the providers 835s
3) Services that the provider will be claiming for – in addition to MediCal and Indigent (Non-Medi-Cal) outpatient services, does the provider claim for Katie A, Day Treatment (Day Treatment – Full and/or Half Day; Day Rehab – Full and/or Half Day), CalWORKs, COS, Inpatient, Residential or PHF services? Confirming the services provided will define the scenarios required to establish provider claiming readiness.

### *Verification of Client's Financial Eligibility:*

Provider will create Clients and the related Financial Eligibility using Web Services for all identified provider services. The Provider will submit a listing of the Clients to the IBHIS Integration Team for validation.

1) MediCal Client: Financial Eligibility set up in Guarantor Order as follows:
    (1) MediCalGuarantor with Guarantor Name of Medi-Cal
    (2) NonMediCalGuarantor with Guarantor Name of LA County
2) Katie A MediCal Client: Financial Eligibility set up in Guarantor Order as follows:
    (1) MediCalGuarantor with Guarantor Name of Katie A. Medi-Cal
    (2) NonMediCalGuarantor with Guarantor Name of LA County
3) Indigent Client (Non-Medi-Cal): Financial Eligibility set up in Guarantor Order as follows:
    (1) NonMediCalGuarantor with Guarantor Name of LA County
4) Medi-Medi or OHC-MediCal client:
   For Medi-Medi, Financial Eligibility set up in Guarantor Order as follows:
    (1) MediCareOHCGuarantor with Guarantor Name of Medicare
    (2) MediCalGuarantor with Guarantor Name of Medi-Cal
    (3) NonMediCalGuarantor with Guarantor Name of LA County
   For OHC-MediCal client, Financial Eligibility set up in Guarantor Order as follows:
    (1) MediCareOHCGuarantor with Guarantor ID Name for OHC payer at the discretion of the provider. (See IBHIS website - http://lacdmh.lacounty.gov/hipaa/IBHIS_EDI_Technical_Specifications.htm; DMH IBHIS Dictionary Values; Guarantor Name Listing – D.55 Guarantor Name)
    (2) MediCalGuarantor with Guarantor Name of Medi-Cal
    (3) NonMediCalGuarantor with Guarantor Name of LA County
5) Day Treatment client: Financial Eligibility set up in Guarantor Order as follows:
    (1) MediCalGuarantor with Guarantor Name of Medi-Cal
    (2) NonMediCalGuarantor with Guarantor Name of LA County
6) CalWORKS client: Financial Eligibility set up in Guarantor Order as follows:
    (1) NonMediCalGuarantor with Guarantor Name of CalWORKs
    (2) MediCalGuarantor with Guarantor Name of Medi-Cal
    (3) NonMediCalGuarantor with Guarantor Name of LA County
7) Residential client: Residential Episode created at the Residential Program of Service level with Guarantor Order as follows:
    (1) MediCalGuarantor with Guarantor Name of Medi-Cal
    (2) NonMediCalGuarantor with Guarantor Name of LA County
8) Inpatient client: Inpatient Episode created at the Inpatient Program of Service level with Guarantor Order as follows:
    (1) MediCalGuarantor with Guarantor Name of Medi-Cal
    (2) NonMediCalGuarantor with Guarantor Name of LA County
9) PHF client: PHF Episode created at the PHF Program of Service level with Guarantor Order as follows:
    (1) MediCalGuarantor with Guarantor Name of Medi-Cal
    (2) NonMediCalGuarantor with Guarantor Name of LA County

### *Claiming Cycle 1 Verification:*

Following the positive validation of the client's Financial Eligibility, the Provider will submit claims in the following listed scenarios, and while submitting the files, please adhere to the naming convention of <ProviderInitial>_<DUNSnumber>_837P_Scen_<Scenario Number>_<YYYYMMDD> .txt (e.g. SSG_000000000_837P_Scen1_20140201.txt)

1) MediCal Client - Financial Eligibility for MediCal (10) and LA County (16)
   a) One outpatient service utilizing a service code of the provider's choice
2) Katie A Client - Financial Eligibility for Katie A (18) and LA County (16). This scenario only applies to Legal Entities who are approved to use the Katie A service codes:
   - Intensive Care Coordination – ICC – T1017:HK
   - Intensive Home Based Services - IHBS – H2015:HK

   a) One outpatient service utilizing either the T1017:HK or H2015:HK service code
      Note: the Katie A service codes are only used on claims that have 'SFC TFC-Treatment Foster Care MC' (004901), 'SFC Wraparound MC' (005001), 'MHSA FSP Wraparound MC' (002201) and 'MHSA FCCS MC' (000114) authorizations.
3) Indigent Client (Non-Medi-Cal) - Financial Eligibility for LA County (16)
   a) One outpatient service utilizing a service code using P Authorization for Non-MediCal Funding Source
4) Medi-Medi or OHC-MediCal Client
   a) One outpatient service utilizing a service code with partial payment from payer (CO)
5) Day Treatment Client - DMH will provide the Member Authorization # and allowable dates of service for claiming as follows:
   a) One Day Treatment or Day Rehab service code using the assigned M Authorization
6) CalWORKs Client
   a) One CalWORKs service utilizing the CalWORKs P Authorization
7) Residential Client
   a) One residential service
8) Inpatient Client
   a) One inpatient service - Inpatient Hospital and/or Admin Hospital Day (mode 5)
9) PHF Client
   a) One PHF service
10) COS Claim using the default COS client
   a) One COS service

Claiming Cycle 1 verification will be considered complete when the provider has submitted an Approved claim for each category above.

### *Claiming Cycle 2 Verification:*

Once the 1st cycle of Provider Claim Readiness has been validated and communicated to the Provider, the provider will submit 2 claims to Replace claims that were submitted in the 1st claim cycle. The Provider will submit claims as follows:

1) Replace a Claim from Claiming Cycle 1 using the duplicate modifier '59'
   Note: the Katie A service codes do not use the '59' modifier. Do not replace the Scenario 2 claim using the duplicate modifier '59'
   Note: the non-Medi-Cal Funding Sources do not use the '59' modifier. Do not replace the Scenario 3 claim using the duplicate modifier '59'
2) Replace a Claim from Claiming Cycle 1 using the duplicate modifier '76'
   Note: the non-Medi-Cal Funding Sources do not use the '76' modifier. Do not replace the Scenario 3 claim using the duplicate modifier '76'

Claiming Cycle 2 verification will be considered complete when the provider has submitted an Approved claim for each category above.

### *Claiming Cycle 3 Verification:*

Once the 2nd cycle of Provider Claim Readiness has been validated and communicated to the Provider, the provider will submit 1 claim to Void a claim that was submitted in the 1st claim cycle. The Provider will submit the claim as follows:

1) Void an Approved Claim from Claiming Cycle 1

Claiming Cycle 3 verification will be considered complete when the provider has submitted an Approved claim for each category above.

## *Document Revision History:*

| Version | Release Date | Comments/ Indicate Sections Revised |
|---|---|---|
| 7.0 | 9/17/14 | 1) Broke up Cycle 2 (Voids and Replacements) to Cycle 2 (Replacements) and Cycle 3 (Voids)<br>2) Revised Verification of Client's Financial Eligibility section to be consistent with recent changes to Client Web Services Financial Eligibility transactions<br>3) Clarification on the Cycle 1 Katie A scenario<br>4) Addition of a Document Revision History |
| 8.0 | 2/20/15 | 1) Removed comment about using 13/14 P-Auths. |